Family PACT (Planning, Access, Care and Treatment) Quality Improvement and Utilization Management (QI/UM) Methodologies

Average Family PACT Reimbursement per Client

Although the average reimbursement per client is calculated for a six-month period, the measure is annualized to provide a more meaningful, easier to interpret number. To accomplish this, an annual client cohort is constructed from the clients served[1] by a clinician provider over 12 months – the six-month period of interest plus the previous six months. So that paid claims for a particular client may be reasonably assumed to be the result of a particular provider's care, clients served by more than one enrolled clinician provider[2] within the last 12 months are excluded from this measure.

Next, all paid claims including clinical, laboratory, and pharmacy claims attributable to the annual client cohort during the six-month period of interest are summed and then divided by the number of clients within the cohort. The resulting average reimbursement per client is then multiplied by two to produce an annualized measure.

[1] A served client is defined as a client with a paid Family PACT claim.
[2] An enrolled clinician provider is defined as a Medi-Cal provider number belonging to a clinician provider who is enrolled in Family PACT.

Family PACT Encounters per Client

As with the average reimbursement per client, the number of encounters per client is best understood when annualized. So again an annual client cohort is constructed of all clients who have had a clinician encounter[3] within a 12-month period – the six-month period of interest plus the previous six months. Next, the number of encounters attributable to this client cohort is calculated and then divided by the number of clients in the cohort. The result is then multiplied by two to produce an annualized measure.

[3] A clinician encounter is defined as one or more paid claims on a date of service for any of the following Current Procedural Terminology (CPT) codes: 99201-04, 99211-14, Z9750-54, Z9760, and Z9761. Note that clients who were seen during the 12-month period without one of these codes are not included in this measure.

Pregnancy Tests per 100 Family PACT Encounters

The number of pregnancy tests per 100 encounters is constructed by dividing the number of paid claims for a pregnancy test (CPT 81025) by the number of encounters.[4] The result is multiplied by 100. Note that if your practice does not successfully bill Family PACT for pregnancy tests and encounters (as it has been defined above) under the same provider number, your result will be inaccurate.

[4] See Encounters per Client for the definition of an encounter.

Social Security Number (SSN) Reporting Among United States (U.S.) Born Family PACT Adults

Percent U.S. Born Clients Certified that Provide a SSN: A client is considered to be U.S. born if he/she has self-indicated as such during the enrollment process. The number of clients whose Health Access Program record contains a SSN[5] is divided by the number of U.S. born clients certified/recertified during the six-month period of interest. The result is multiplied by 100 to produce the percentage with a valid SSN.

[5] A Social Security Number must conform to the format described by the Social Security Administration to be counted as valid.

Chlamydia Screening Rate for Sexually Active Women Under 26 Years of Age[6]

The chlamydia screening rate among sexually active women under 26 is calculated by constructing a cohort of eligible clients[7] served by a Family PACT provider during a six-month period of interest. A client is considered screened if she has had a Family PACT laboratory claim, paid or denied, for a chlamydia test[8] within 12 months prior to her last date of service within the period.[9] Note that your practice is credited with the screening even if the screening is performed by a different provider, as long as it is billed to Family PACT.

Chlamydia Screening Rate for Sexually Active Women Ages 26 and Older

The chlamydia screening rate among sexually active women 26[6] and over is calculated by constructing a cohort of eligible clients[7] served by a Family PACT provider during a six-month period of interest. A client is considered screened if she has had a Family PACT laboratory claim, paid or denied for a chlamydia test[8] within 12 months prior to her last date of service within the period.[9] Note that your practice is credited with the screening even if the screening is performed by a different provider, as long as it is billed to Family PACT.

[6] Age is calculated as the woman's age midway through the period of interest.
[7] If primary diagnosis code S60 (Pregnancy Testing) is the only service a woman was seen for during the period of interest, she is excluded from the cohort.
[8] A chlamydia test is defined as a paid Family PACT claim for any of the following CPT codes: 87110, 87270, 87490, 87491, 87800, and 87801.
[9] A client whose last date of service is within seven days of the end of the period and was screened within seven days after that visit is counted as having been screened.

Percent of Family PACT Evaluation and Management (E&M) Visits for Established Clients Coded 99214 (Level Four)

The percent of E&M visits that are at the highest level is constructed by first counting the number of paid claims for E&M visits with the CPT code 99214 during the period of interest. That number is then divided by the total of all E&M visits (CPT codes 99211-99214). The result is multiplied by 100 to produce the percentage at the highest level.

Percent of Family PACT Education and Counseling (E&C) Visits Coded Z9754

The percent of E&C visits that are at the highest level is constructed by first counting the number of paid claims for E&C visits with the CPT code Z9754 during the period of interest. That number is then divided by the total of all E&C visits (CPT codes Z9750-Z9754). The result is multiplied by 100 to produce the percentage at the highest level.